Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dave McKillop, a prisoner at HMP Stafford, on 15 January 2025

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Dave McKillop was found hanged in his cell on 15 January 2025 at HMP Stafford. He was 53 years old. I offer my condolences to Mr McKillop's family and friends.

Mr McKillop had significant risk factors for suicide and attempted to strangle himself some weeks before his death. He was monitored under suicide and self-harm prevention procedures for a period, including by constant supervision. We consider that the management of these processes was good and he received effective support. Staff reasonably ended suicide and self-harm prevention procedures a few days before Mr McKillop's death. We found no evidence that staff should have considered him at imminent risk of suicide or self-harm in the immediate days before his death.

The clinical reviewer found that the healthcare Mr McKillop received was equivalent to that he would have received in the community.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **August 2025**

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Summary

Events

1. On 8 November 2024, Mr Dave McKillop was recalled to prison at HMP Leicester after failing to comply with his licence conditions while living at an approved premises. Mr McKillop moved to HMP Stafford on 14 November.

2. On 20 December, staff started prison suicide and self-harm support procedures (known as ACCT) when they saw him trying to strangle himself using shoelaces. Staff closed the ACCT on 10 January 2025, after a period of stability and when Mr McKillop said that he had no current thoughts of suicide or self-harm and that he would seek help if his mood deteriorated.

3. On the morning of 15 January 2025, Mr McKillop left his cell to receive his medication at 8.06am and his cellmate went to work shortly after. Mr McKillop returned to his cell at 8.39am. At 10.47am, an officer unlocked Mr McKillop's cell for lunch and another prisoner saw him hanging from his toilet door. The prisoner called to an officer who radioed a medical emergency, cut the ligature and started cardiopulmonary resuscitation (CPR). A prison paramedic and a nurse arrived and they took charge of Mr McKillop's care.

4. Ambulance paramedics arrived at 11.00am and took over efforts to resuscitate Mr McKillop, but without success. At 11.25am the paramedics pronounced life extinct.

5. Mr McKillop had left a lengthy letter in his cell in which he detailed extensive sexual abuse during his childhood and explained that he could not continue living with the trauma of the abuse.

Findings

6. The decision to end ACCT procedures on 10 January was reasonable.

7. When an officer unlocked cells at around 7.30am on the morning of 15 January, he did not make welfare checks on prisoners.

Recommendations

- The Governor should ensure that staff make welfare checks when unlocking cells and should arrange an audit to ensure that staff adhere to policy.

The Investigation Process

8. HMPPS notified us of Mr McKillop's death on 15 January 2025.

9. The investigator issued notices to staff and prisoners at HMP Stafford informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator visited Stafford on 22 January 2025. He obtained copies of relevant extracts from Mr McKillop's prison and medical records. He met the Governor and Deputy Governor and he spoke to four prisoners.

11. The investigator interviewed 13 members of staff at Stafford on 10 and 11 March.

12. NHS England commissioned a clinical reviewer to review Mr McKillop's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed healthcare staff.

13. We informed HM Coroner for Staffordshire and Stoke-on-Trent of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. We attempted to contact Mr McKillop's ex-partner to explain the investigation and to ask if she had any matters she wanted us to consider. However, we were unable to make contact with her.

15. We shared our initial report with HMPPS. HMPPS did not identify any factual inaccuracies but provided an action plan in response to our recommendation.

Background Information

HMP Stafford

16. HMP Stafford is a medium security training prison for adult male prisoners convicted of sexual offences. Practice Plus Group (PPG) provides healthcare services. Mental healthcare and psychosocial substance misuse services are sub-contracted to Inclusion.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Stafford was in November and December 2024. Inspectors reported that Stafford was a well maintained prison. Relationships between prisoners and staff were good and the atmosphere was calm and safe. Inspectors found that the quality of case management of prisoners supported through ACCT was good, and better than normally seen. Inspectors noted that ACCT assessments were on-time, reviews were multidisciplinary and paperwork was in order. Inspectors noted that most prisoners knew who their key worker was and 79% found their key worker helpful. Inspectors found that delivery of key worker sessions had improved since the previous inspection with more than 70% of planned session being delivered.

18. Inspectors noted that prisoners received high quality care from the primary care team. Inspectors reported that there was considerable pressure on the small Inclusion team delivering mental health provision. They noted that complex patients, large caseloads and other pressures affected delivery of care. They noted that the clinical records they reviewed were generally acceptable with up to date risk assessments and patient centred care plans.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to April 2024, the IMB noted that compared to other similar establishments, Stafford remained a low risk, safe prison which reflected the hard work of the staff. The IMB found that pressure had been maintained by management to increase both the number and quality of key work sessions and that where targets were not met, this was due to unplanned events such as hospital visits.

Previous deaths at HMP Stafford

20. Mr McKillop was the 29th prisoner to die at Stafford since November 2021. Of the previous deaths, two were self-inflicted, one was drug related and 25 were from natural causes.

21. In our investigation into a self-inflicted death in August 2022, we found that the control room officer who made the emergency call to the ambulance service was not in possession of all the information necessary to allow the ambulance service to properly triage the call.

22. In our investigation into a death from natural causes in December 2024, we found that staff who responded to the emergency call did not activate their body worn cameras.

23. Up to the end of May 2025, there had been no further deaths at Stafford since that of Mr McKillop.

Assessment, Care in Custody and Teamwork (ACCT)

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

25. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in the Prison Safety Policy Framework.

Key worker scheme

26. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm, and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners, and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework. This says:

    - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.

    - Key workers must have completed the required training.

    - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

27. Within this allocated time, key workers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

28. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to

increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

29. In February 2004, Mr Dave McKillop was sentenced to life imprisonment with a minimum tariff of 54 months for sexual offences. He was released on licence in March 2019.

30. In early 2024, the Probation Service made two variations to Mr McKillop's licence conditions following concerns about his recent behaviour and a deterioration in his compliance with his licence conditions. The concerns included that Mr McKillop had resumed drinking alcohol after abstaining for 24 years, that he was in possession of more than one mobile telephone and he had formed a rapidly developing new relationship with a potentially vulnerable partner with four children. When Mr McKillop's offender manager made an unannounced visit to his home in early October, she identified further concerns including that Mr McKillop had not disclosed the nature of his offence to his new partner. On 14 October, Mr McKillop was directed to reside at an approved premises in the hope that his behaviour and compliance with his licence conditions would stabilise.

31. On the evening of 5 November, Mr McKillop failed to return to the premises for the 7.00pm curfew. He had still not returned by 8.00pm and he had turned off his telephone so did not respond to efforts to contact him. As a result, his offender manager instigated his recall to prison and on 8 November 2024, he was recalled to custody at HMP Leicester.

HMP Stafford

32. On 14 November, Mr McKillop transferred to Stafford

33. On arrival at Stafford, Mr McKillop saw Nurse A for a reception health screen. Mr McKillop said that he had problems with his balance after breaking his ankle in 2008 (entries in his medical record confirmed that he walked with a limp and used a walking stick). Nurse A noted that Mr McKillop suffered with depression and had complex post-traumatic stress disorder (PTSD - stress caused by a traumatic event or series of events often from many years earlier). He said that he had not received any medication since his recall to prison and she assured him that he would be prescribed medication the next day. Mr McKillop said that he had attempted suicide two to three months before by taking an overdose, but he had no current thoughts of suicide or self-harm. Nurse A referred Mr McKillop for a mental health review.

34. An officer on the induction wing (D wing) noted that Mr McKillip received welfare checks through his first night with no concerns.

35. On 15 November, another officer met Mr McKillop for a combined key work and second day induction meeting. Mr McKillop said that he had no concerns about being in Stafford and his first impressions of the prison were positive. He also said that he was interested in getting a job to keep busy. The officer gave Mr McKillop information about Stafford and told him that a new key worker would be allocated to him following the induction period.

36. On 20 November, Nurse B from the mental health team saw Mr McKillop for a mental health assessment and he was then discussed at a team meeting the following day. The team noted that Mr McKillop had reported frequent nightmares and flashbacks (relating to his PTSD) but he said that these were under control and he reported having a lot of coping strategies. He said though that his prescribed antidepressant, mirtazapine, was not helping. The team noted that Mr McKillop was not presently suitable to be taken onto the team's workload, but that they would have input at the time of his parole. They also noted that the GP would review Mr McKillop's medication.

37. On 26 November, an independent nurse prescriber, saw Mr McKillop for a medication review. The nurse prescriber told the investigator that after assessing Mr McKillop he prescribed him a different antidepressant, paroxetine.

38. On the evening of 7 December, Mr McKillop asked to speak to Listeners (prisoners trained by the Samaritans to provide confidential peer support). After speaking to the Listeners, Mr McKillop told an officer that he did not have any thoughts of suicide or self-harm but he said that he struggled with anxiety and PTSD at times and that was why he had asked for Listeners.

39. On 13 December, an officer met Mr McKillop for a key work session. Mr McKillop said that he suffered with anxiety and PTSD so he preferred to stay in his cell. The officer suggested to Mr McKillop that he should try to mix with other prisoners on the landing. He also told him that he had been allocated to one of the prison workshops and would start work in due course.

40. At a routine check on the evening of 20 December, staff saw Mr McKillop trying to strangle himself with shoelaces. An officer noted that Mr McKillop seemed frightened and he asked the officers not to beat him up. Officers called for a nurse to check Mr McKillop and they then started ACCT procedures and moved him to a high observation cell under constant supervision (where officers remain at the door 24 hours a day).

41. The constant supervision officer during the early morning of 21 December noted that she had spoken to Mr McKillop after he woke at 6.00am. Mr McKillop said that he did not come out of his cell as he was scared of being attacked. The officer tried to reassure Mr McKillop and she asked him whether he had thoughts to end his life and also asked him about family and friends. Mr McKillop said that he did have thoughts of suicide. He also said that the only person he was in contact with was his ex-partner. He said that he spoke regularly to her, but she had told him that she no longer wanted to be in a relationship with him.

42. Ms A chaired a multidisciplinary ACCT review with Mr McKillop on 21 December. Mr McKillop said that his actions the day before had been due to living with PTSD and nightmares stemming from childhood abuse. He said that he had received some counselling but the counselling 'had not even touched the surface'. He said that he had spoken to his ex-partner the day before and she had told him that she wanted them to remain friends, but she did not want to continue in a full relationship. He said that he knew that that news 'was coming' and that was not the reason for his attempt to strangle himself. He added that he was feeling better that day than the day before. Ms A maintained Mr McKillop on constant supervision.

43. Ms A chaired a further multidisciplinary review with Mr McKillop on 22 December. She noted that Mr McKillop had had a shower and his appearance and demeanour were much improved compared to the day before. He confirmed that he was feeling better, he was using techniques he had been taught to work through his issues and he did not have any present thoughts of self-harm. Ms A told Mr McKillop that staff would review his situation again the following day but for the moment she wanted him to remain under constant supervision in the high observation cell.

44. Mr McKillop's ACCT contained an undated note from him in which he apologised for his actions in using a ligature on 20 December. He wrote that he was grateful to staff for their support and said that in future he would ask for help.

45. Nurse B arrived early for the ACCT review on 23 December so she spent some time assessing him. She also told him that he had been taken onto the Inclusion team caseload.

46. Ms A again chaired the review that day and Nurse B summarised her earlier meeting with Mr McKillop. Mr McKillop said that he felt much better again than the day before and Ms A noted that it was evident that he was happy that the mental health team had taken him onto their caseload. Mr McKillop said that he felt very supported by staff and would speak to staff or Listeners if his mood declined. Ms A noted that Mr McKillop could return to his cell on D wing and she reduced the frequency with which staff had to check him (also known as observations) to twice an hour.

47. When Mr McKillop went to collect his medication on the afternoon of 25 December, Nurse A thought that he seemed withdrawn and nervous around other prisoners. She noted that he did not make eye contact with her. She spoke to a Supervising Officer (SO) and they then spoke to Mr McKillop in the wing office. Mr McKillop said that he had no thoughts of self-harm but as a precaution overnight, the SO, with Nurse A's agreement, increased Mr Mckillop's observations to five an hour pending an ACCT review the following day. The SO told the Orderly Officer (the senior officer on duty) about the change.

48. At an ACCT review on 26 December, Mr McKillop observations were reduced back to two an hour and at a review on 30 December, were further reduced to three checks during the day with hourly checks during the night.

49. On 30 December, Mr McKillop moved from D wing to a single cell on E wing.

50. On 6 January 2025, another SO (SO A), chaired an ACCT review with Mr McKillop. Nurse B also attended. SO A noted that Mr McKillop initially seemed a little 'guarded' but he engaged more the longer the review went on. Mr McKillop said that he had fleeting thoughts of suicide or self-harm at times but had no such thoughts at present and had external support from his ex-partner. SO A maintained Mr McKillop's daytime observations at three during the day, but reduced his night-time observations to three during the night.

51. On the afternoon of 6 January, a prisoner alerted staff that Mr McKillop had collapsed in his cell. An officer noted that Mr McKillop was lying face down on his cell floor with a small pool of blood by his head. The officer radioed a medical emergency. A nurse responded and noted that Mr McKillop was unresponsive when

she arrived but he quickly regained consciousness. She noted that Mr McKillop had a cut lip and reported a headache, blurred vision, dizziness and nausea. Mr McKillop was sent to hospital for further assessment. He was discharged from hospital that evening with a diagnosis that he had fainted.

52. On 7 January, Mr McKillop moved to cell E1-12, a double cell which he shared with Prisoner A. (He was moved to a shared cell for his own safety following his faint and collapse the previous day.)

53. On the morning of 8 January, Mr McKillop told an officer that he wanted to speak to Listeners. After speaking to the Listeners, Mr McKillop told the officer that he had been struggling to sleep at night and had just wanted someone to talk to. The officer noted that Mr McKillop said that he was 'perfectly fine' and had no thoughts of harming himself. The officer told the investigator that Listeners will report to staff if they have concerns about a prisoner's welfare but they raised no concerns about Mr McKillop.

54. On 10 January, the nurse prescriber saw Mr McKillop for a medication review. He noted that he had no plans to change the medication at that time and would review Mr McKillop again in three months. The nurse prescriber noted that Mr McKillop attended healthcare without his ACCT document. He told the investigator that prisoners on ACCT never attended consultations with their ACCT documents. (Under policy, the prisoner's ACCT document should follow them as they move around the prison so any member of staff can read relevant risk information and make entries as necessary.)

55. Later on 10 January, SO A chaired a further ACCT review with Mr McKillop. Nurse D and Nurse E from the Inclusion team also attended. SO A noted that Mr McKillop was content with his cellmate. He said that he had good and bad days with fleeting thoughts of self-harm, but said that he was managing his thoughts with distractions such as listening to music. He said that this had been a pattern for many years. SO A noted that the nurses were going to add Mr McKillop to the waiting list to join the Senior Support Group (SSG - an association group generally comprising older unemployed prisoners). Mr McKillop said that he was pleased that his name had been added to the list. SO A noted that he explicitly asked Mr McKillop if he had ideas of suicide or self-harm and he said that he had none and would seek help if his mood dipped. He also said that he was receiving a lot of support from his ex-partner. SO A noted that the 'collective decision' of the panel was that Mr McKillop no longer needed support through ACCT. (As part of ACCT procedures, staff were required to record his progress over the following week using a '7-day post-closure monitoring form'.)

56. Prisoner A told the investigator that either on the Sunday or Monday before his death, Mr McKillop gave him his prison shop purchases. He did not explain his reasons and he (Prisoner A) just thought it was a friendly gesture. He did not notice any change in Mr McKillop's demeanour.

57. As Mr McKillop had problems with his balance, he was allocated a carer, another prisoner, Prisoner B. Prisoner B told the investigator that his responsibilities for Mr McKillop were to deliver his meals, to collect his used plates, to collect and deliver his laundry and to take him by wheelchair to healthcare appointments. He said that he and Mr McKillop exchanged pleasantries, but they did not speak about anything

in depth. He said that he noticed no change in Mr McKillop's demeanour in the final days before his death.

58. The investigator listened to all of Mr McKillop's telephone conversations between 5 January and his final call on 14 January. The majority of his calls were to his ex-partner and he also made a number of calls to a male friend. In his calls to his ex-partner, it was clear that their relationship had ended, but they wanted to remain friends. In his conversations with his male friend, Mr McKillop asked for his help in retrieving his belongings from his ex-partner's home. He also mentioned that he had applied to join the SSG. His final call to his male friend was at 8.17am on 14 January when the friend told him that he had been trying to contact Mr McKillop's ex-partner to collect his property. Mr McKillop said nothing in any of the calls to suggest he was thinking about taking his life.

59. The entries in Mr McKillop's 7-day post-closure monitoring form from 10 to 14 January show that he engaged with other prisoners during association periods, he consumed his meals and staff identified no concerns in his demeanour.

Events of 15 January

60. The investigator watched CCTV footage and body worn video camera footage (BWVC). He also obtained information from West Midlands Ambulance Service. The following account is based on these sources as well as statements and interviews with staff and prisoners.

61. At 7.30am, Officer A unlocked the cells on Mr McKillop's landing (the investigator noted that he did not look into the cells to check on prisoners' wellbeing). A few minutes later, Prisoner B went to the cell to collect Mr McKillop's used dishes.

62. At 8:06am, Mr McKillop came out of his cell and left the landing to receive his medication. Prisoner A left the cell a few minutes later to go to work. He told the investigator that before going to work, he and Mr McKillop had laughed about the news that morning of the resignation of a cabinet minister following allegations of corruption.

63. At 8:39am, Mr McKillop returned to his landing but found that his cell was locked. He went to look for an officer and one minute later he returned to his cell with Officer B. In the minute that Mr McKillop was away, a works operative had gone into the cell to check the smoke detector. The operative then left and Mr McKillop went into his cell and Officer B locked the door.

64. At 10:47am, Officer B unlocked the cells for prisoners to collect lunch. Prisoner A was still at work. Prisoner B was immediately behind Officer A and he went into the cell to collect Mr McKillop's used dishes. He saw Mr McKillop hanging from the toilet door and he shouted to staff.

65. Officer A went to the cell and saw Mr McKillop hanging. He radioed a medical emergency code blue (indicating that a prisoner had either stopped or was having difficulty breathing) and he also shouted out to his colleagues. Officer A held Mr McKillop with one arm and cut the ligature. He lowered Mr McKillop to the floor and cut the remaining part of the ligature that was still tight around Mr McKillop's neck. Officer B helped move Mr McKillop onto his back and Officer A started CPR. Officer

A told the investigator that when he first took hold of McKillop it was clear to him that he was not breathing so he did not want to waste time in checking him for a pulse before starting CPR.

66. Mr A, a paramedic, told the investigator that he was just outside E wing when he heard the code blue so he arrived quickly to the cell (CCTV shows that he arrived 70 seconds after the code blue call). Mr A and Officer A moved Mr McKillop from his cell onto the landing where there was more room and Mr A took over giving CPR. Officer B brought a defibrillator and Nurse A also arrived. Staff continued to give CPR, they gave oxygen and periodically checked Mr McKillop with the defibrillator.

67. Control room staff called an ambulance when the code blue call was made. Ambulance paramedics reached Mr McKillop at 11.00am. They took charge of the efforts to resuscitate Mr McKillop, but all efforts to resuscitate him proved unsuccessful and at 11.25am the paramedics declared life extinct.

68. At interview, Mr A and Nurse A both said that they asked staff to inform the control room that the situation was urgent and the ambulance needed to be fast tracked, however the ambulance had been delayed for several minutes at the prison gate. The evidence from West Midlands Ambulance Service included that the ambulance had been kept waiting at the gate for one to two minutes and that they were unaware that the prisoner was in cardiac arrest secondary to hanging.

69. Mr McKillop left a five page letter in his cell in which he detailed extensive sexual abuse that he had suffered as a child. He wrote that he was ‘hurting so much inside’ that he could not ‘carry on anymore’.

Contact with Mr McKillop’s family

70. Stafford appointed a family liaison officer (FLO). The FLO and a senior colleague drove to the address held for Mr McKillop’s ex-partner. They arrived at around 2.45pm and were met by the ex-partner’s mother who said that her daughter was living at a different address. The FLO and her colleague drove to the new address and met Mr McKillop’s ex-partner at around 4.00pm. They broke the news of Mr McKillop’s death and offered their condolences.

71. Stafford contributed to the cost of Mr McKillop’s funeral in line with national instructions.

Support for prisoners and staff

72. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners to identify prisoners most affected by the death.

73. After Mr McKillop's death, Stafford's Head of Residence, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

74. The prison posted notices informing other prisoners of Mr McKillop's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr McKillop's death. Listeners were made available to other prisoners.

Post-mortem report

75. The pathologist gave Mr McKillop's cause of death as asphyxia due to hanging.

76. Toxicology results found that Mr McKillop's blood sample contained presence of several medicines. Some of these were medicines prescribed to Mr McKillop and another was one believed to have been given to him during his emergency treatment on 15 January. The toxicologist noted that it was unlikely that the medicines, at the concentrations detected, would have caused acute toxicity.

Findings

Assessment of risk

77. Up to 31 December 2024, Prison Service Instruction (PSI) 64/2011, governed staff responsibilities regarding ACCT suicide and self-harm prevention procedures. From 1 January 2025, a revised Prison Safety Policy Framework was fully implemented to replace PSI 64/2011. Both of these policy documents make clear the need for staff to recognise the risk factors and triggers that might increase the risk of suicide and self-harm and they contain mandatory instructions on the use of ACCT procedures to manage prisoners identified to be at risk.

78. Mr McKillop had several risk factors for suicide and self-harm including a history of suicide attempts, diagnoses of mental illness, difficult childhood experiences and his relatively recent recall to prison as a life sentence prisoner. Staff started ACCT procedures for Mr McKillop when he was seen attempting to strangle himself with shoelaces on the evening of 20 December and he was placed under constant supervision. He remained under constant supervision until 23 December when staff began reducing the frequency of welfare checks. Mr McKillop made no further attempts to harm himself during the following weeks. He generally engaged well at ACCT reviews explaining that he suffered with PTSD and had regular recurring nightmares. (Mr McKillop wrote extensively in the letter discovered after his death about his extremely traumatic childhood and which possibly accounted for his PTSD and nightmares.)

79. At an ACCT review on 10 January, Mr McKillop spoke about the support he was receiving from his ex-partner. He said that he was pleased at the prospect of attending the SSG. He also said that he did not have any current thoughts of suicide or self-harm and said that he would seek help if needed. The review panel felt assured that Mr McKillop was not currently at risk and they closed the ACCT. Entries in Mr McKillop's ACCT post-closure monitoring form in the following days indicate that he appeared settled. We consider that the decision to close Mr McKillop's ACCT on 10 January was reasonable and on the evidence we have seen, there was no particular reason for them to consider him at significant risk of suicide before his death.

80. We note, however, that Mr McKillop had four different ACCT case managers when instructions say that prisons should aim to maintain consistency in case management. There were reasons for these changes; three of the reviews were chaired by a senior manager when Mr McKillop was subject to constant supervision and there was a change in case manager when Mr McKillip moved to a different wing. However, the Governor will wish to ensure that case managers remain consistent where possible.

Availability of ACCT document

81. The investigator spoke to Stafford's Head of Safer Custody, about the nurse prescriber's evidence that prisoners who were being supported through ACCT never attended consultations with their ACCT documents. The Head of Safer Custody told the investigator that she met the nurse prescriber regularly during

various safety meetings and he had never raised this issue with her. She confirmed that it was a requirement that ACCT documents should follow the prisoner to all of their daily activities and other appointments. Following the discussion between the investigator and the Head of Safer Custody, Stafford reissued a previous information notice reminding staff that they should take the ACCT document with the prisoner when attending appointments and hand the document to the person seeing the prisoner for the relevant activity. In view of the action already taken by Stafford, we make no recommendation, but the Head of Safer Custody will want to monitor staff's compliance with the instruction.

Key Work

82. Mr McKillop had a standard preliminary key work meeting on his second day at Stafford but did not have any other key work meetings during his two months at Stafford. The Head of Safer Custody told the investigator that prisoners receive a preliminary key work meeting on their second day at Stafford and thereafter, should receive one key work session every two weeks. She said that in the period 15 December 2024 to 15 January 2025, Stafford achieved 63% of its target of delivery of key work sessions. She acknowledged however that operational issues, such as the need to send officers out for hospital escorts impacted on delivery of key work sessions.

83. We are aware that many prisons are currently having difficulty in achieving targets for delivery of key work. However, we urge the Governor to strive towards full delivery of the key worker scheme.

Welfare checks

84. PSI 75/2011 says that prisons need to have clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock. Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process. Stafford's local policy on roll check procedures says that when checking the roll, staff must assure themselves that prisoners are in their cells by obtaining a clear view of their face, if necessary, by waking them.

85. When the investigator viewed the CCTV footage he noted that Officer A did not make welfare checks when he unlocked cells at 7.30am on the morning of 15 January. Although Mr McKillop was still alive and well at this time we nevertheless make the following recommendation:

    The Governor should ensure that staff make welfare checks when unlocking cells and should arrange an audit to ensure that staff adhere to policy.

Delay in ambulance reaching Mr McKillop

86. Mr A and Nurse A both said that while they were treating Mr McKillop they asked officers to inform the communications room staff that Mr McKillop was in cardiac arrest so that they could tell the 999 call handler and they also asked for the ambulance to be brought into the prison as quickly as possible. The investigator assessed that it took eight minutes for the paramedics to reach Mr McKillop from

the point they arrived at the prison gate and it was only when they reached Mr McKillop that they learned that he had suffered a cardiac arrest after hanging. The records made by the paramedics confirm this information. The investigator was not able to establish precisely what information was conveyed between healthcare staff and the officers present at the scene.

87. Ms B told the investigator that at the time staff were dealing with the emergency response for Mr McKillop, she was in the command suite dealing with the death of another prisoner an hour earlier. She said that at the time there was a lot of radio communication taking place. She confirmed that the prison used the standard code blue and code red messages to indicate emergencies relating to breathing difficulties or loss of blood which meant that control room staff might not immediately have all the information that the ambulance service would need to prioritise the response. (Generally, call handlers need to know whether the patient is conscious and breathing to dispatch a priority ambulance.)

88. Following Mr McKillop's death, Stafford issued an information notice to remind staff that control room staff should be kept up to date with emerging information at the scene including a description of the emergency and that any significant changes in the situation should be conveyed immediately to the control room. In light of the action taken by Stafford, we make no recommendation.

89. We have raised our concerns to HMPPS about the process of control room staff passing vital information on the patient's condition to emergency operators in previous investigations. HMPPS reviewed processes and concluded that the focus of action would be on control room staff. We consider that such an approach is unlikely to drive effective change and that issues such as arose in this case will continue until a more effective solution (for example ensuring that a senior member of staff is present in the control room to coordinate the emergency response) is found.

Clinical care

90. The clinical reviewer concluded that Mr McKillop's care at Stafford was of a good standard and was equivalent to that he could have expected to receive in the community. She found that all care was delivered in a timely and appropriate manner and noted that there was clear evidence of a positive and supportive team approach across the healthcare service, with good working relationships between healthcare and prison staff leading to well-coordinated delivery of care. The clinical reviewer made no recommendations.

Governor to note

91. When Officer A went into Mr McKillop's cell on 15 January and saw him hanging, he radioed a medical emergency, shouted to colleagues for support and on his own both supported Mr McKillop's body and cut the ligature before lowering Mr McKillop to the floor. He then cut the remaining part of the ligature from Mr McKillop's neck and started CPR. Officer A did not turn on his body worn camera until after Mr McKillop had been brought out of his cell. He said that the delay in activating his camera was because his priority was trying to preserve Mr McKillop's life. Officer A responded efficiently when he saw Mr McKillop hanging and removed the ligature

without delay and we commend him for that. We can understand why he did not immediately think about his body worn camera. We have, however, recently brought to the Governor's attention a similar situation during an emergency response and asked the Governor to ensure that staff are reminded of the importance of activating body worn cameras.

Inquest

92. An inquest into Mr McKillop's death that concluded on 9 June 2026 found the cause of his death was asphyxiation due to hanging.

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